

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577 Report Period Beginning: 02/01/00 Ending: 01/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,934</u>	5
6		ICF/DD 16 or Less			6
7	<u>177</u>	TOTALS	<u>177</u>	<u>64,782</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,148</u>	<u>390</u>	<u>2,367</u>	<u>3,905</u>	8
9	SNF/PED					9
10	ICF	<u>8,401</u>	<u>31,277</u>	<u>69</u>	<u>39,747</u>	10
11	ICF/DD					11
12	SC	<u>0</u>	<u>7,234</u>	<u>0</u>	<u>7,234</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,549</u>	<u>38,901</u>	<u>2,436</u>	<u>50,886</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.55%

D. How many bed-hold days during this year were paid by Public Aid?

84 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/06/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 16 and days of care provided 2,102Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 01/31/01 Fiscal Year: 01/31/01

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/00 Ending: 01/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	375,962	46,921	(22,970)	399,913		399,913		399,913			1
2	Food Purchase		280,281		280,281		280,281		280,281			2
3	Housekeeping	220,251	25,946	3,990	250,187		250,187		250,187			3
4	Laundry	48,486	6,877	54,178	109,541		109,541		109,541			4
5	Heat and Other Utilities			157,759	157,759		157,759		157,759			5
6	Maintenance	70,223	18,285	84,016	172,524		172,524		172,524			6
7	Other (specify):*			59,449	59,449		59,449		59,449			7
8	TOTAL General Services	714,922	378,310	336,422	1,429,654		1,429,654		1,429,654			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,469,383	210,899	289,528	2,969,810		2,969,810		2,969,810			10
10a	Therapy		1,623	32,584	34,207		34,207		34,207			10a
11	Activities	143,532	5,050	35,227	183,809		183,809	(2,722)	181,087			11
12	Social Services	74,953	316	26	75,295		75,295		75,295			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,687,868	217,888	369,365	3,275,121		3,275,121	(2,722)	3,272,399			16
	C. General Administration											
17	Administrative	188,022		344,976	532,998	(24,736)	508,262	124,577	632,839			17
18	Directors Fees											18
19	Professional Services			60,070	60,070		60,070		60,070			19
20	Dues, Fees, Subscriptions & Promotions			40,616	40,616		40,616	(1,859)	38,757			20
21	Clerical & General Office Expenses	310,068	12,423	76,473	398,964		398,964	(15,113)	383,851			21
22	Employee Benefits & Payroll Taxes			754,476	754,476	24,736	779,212		779,212			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,655	9,655		9,655	(5,729)	3,926			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,288	18,288		18,288		18,288			26
27	Other (specify):*											27
28	TOTAL General Administration	498,090	12,423	1,304,554	1,815,067		1,815,067	101,876	1,916,943			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,900,880	608,621	2,010,341	6,519,842		6,519,842	99,154	6,618,996			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			187,714	187,714		187,714	11,093	198,807			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			428,878	428,878		428,878	(360,607)	68,271			32
33	Real Estate Taxes			7,840	7,840		7,840	(7,840)				33
34	Rent-Facility & Grounds			1,886	1,886		1,886		1,886			34
35	Rent-Equipment & Vehicles			216	216		216		216			35
36	Other (specify):*											36
37	TOTAL Ownership			626,534	626,534		626,534	(357,354)	269,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	61,953	329,925	56,438	448,316		448,316		448,316			39
40	Barber and Beauty Shops			47,577	47,577		47,577		47,577			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							70,272	70,272			42
43	Other (specify):*			16,732	16,732		16,732	(16,732)				43
44	TOTAL Special Cost Centers	61,953	329,925	120,747	512,625		512,625	53,540	566,165			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,962,833	938,546	2,757,622	7,659,001		7,659,001	(204,660)	7,454,341			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(10,830)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	11,093	30		9
10 Interest and Other Investment Income	(376,741)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(2,146)	21		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(20,885)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (399,509)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	124,577	17	34
35 Other- Attach Schedule Provider Part. Fee	70,272	42	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 194,849		36
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (204,660)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Covenant Health Care Center-Batavia

ID# 0025577

Report Period Beginning: 02/01/00

Ending: 01/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2	Vending, Pers Svc, Other Operating Revenue	(2,137)	21	2
3	Transportation Revenue	(1,258)	11	3
4	Marketing, Emp Recognition Expense	(16,732)	43	4
5	Flowers, Cable TV Access	(1,464)	11	5
6				6
7	Dues, Subscriptions, Public Relations	(1,859)	20	7
8	Travel, Auto, Seminar	(5,729)	24	8
9				9
10				10
11				11
12	Amortize Loss on Early Ext of Debt	16,134	32	12
13	Real Estate Taxes	(7,840)	33	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,885)		49

Summary A

01/31/01

[illegible]

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Summary B

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

02/01/00

Ending:

01/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	11,093	0	0	0	0	0	0	0	0	0	0	11,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(360,607)	0	0	0	0	0	0	0	0	0	0	(360,607)	32
33	Real Estate Taxes	(7,840)	0	0	0	0	0	0	0	0	0	0	(7,840)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(357,354)	0	0	0	0	0	0	0	0	0	0	(357,354)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	70,272	0	0	0	0	0	0	0	0	0	0	70,272	42
43	Other (specify):*	(16,732)	0	0	0	0	0	0	0	0	0	0	(16,732)	43
44	TOTAL Special Cost Centers	53,540	0	0	0	0	0	0	0	0	0	0	53,540	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(329,237)	124,577	0	0	0	0	0	0	0	0	0	(204,660)	45

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/00 Ending: 01/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities	100%	See attached schedule	Various	Covenant Ret. Com	Chicago	Mgt. Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management services	\$ 344,976	Covenant Retirement Communities	100.00%	\$ 469,553	\$ 124,577 1
2	V	19 Consulting services	46,252	Covenant Retirement Communities	100.00%		(46,252) 2
3	V	Detail					3
4	V	19 Data Processing Service				21,322	21,322 4
5	V	19 Audit Service				10,335	10,335 5
6	V	19 Cost Reprt Preparation				5,496	5,496 6
7	V	19 Payroll Preparation				9,099	9,099 7
8	V						8
9	V						9
10	V	22 Pension expense	37,052	Covenant Retirement Communities	100.00%	37,052	
11	V						
12	V						
13	V						
14	Total		\$ 428,280			\$ 552,857	\$ * 124,577 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/00 Ending: 01/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577

Report Period Beginning:

02/01/00Ending: 01/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Covenant Retirement Communities, Inc.
 Street Address 5115 N. Francisco Avenue, Suite # 200
 City / State / Zip Code Chicago, Illinois, 60625
 Phone Number (773) 878-2294
 Fax Number (773) 878-2289

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	17	Management Fees	Actual Net Service						2
3		Revenue	94,229,000	32	4,976,952	1,813,264	6,531,456	344,976	3
4	19	Data Processing	Fixed Per Month (1)	32	476,276	not available	1	21,322	4
5	19	Auditing Services	Fixed Per Month (2)	32	251,837	0	1	10,355	5
6	19	Cost Report Preparation	Fixed Per Month (3)	14	66,960	0	1	5,496	6
7	19	Payroll Services	Dir. Cost From Vendor	1	9,099	0	1	9,099	7
8	22	Pension Expense	Fixed Per Month (4)	32	390,796	0	1	37,052	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21		(1) Data processing is based upon a fixed fee of \$1,777/ month							21
22		(2) Auditing services are based upon a fixed fee of \$863/ month							22
23		(3) Cost Report preparation services are based upon a fixed fee of \$458/ month							23
24		(4) Pension Plan expenses are based upon an estimated fee of \$3,088/ month							24
25	TOTALS				\$ 6,171,920	\$ 1,813,264		\$ 428,300	25

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577

Report Period Beginning:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/00 Ending: 01/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	See Supplemental Schedule I						\$ 7,385,064	\$ 6,090,261			\$ 356,994	1
2	See Supplemental Schedule II						255,269	162,466			71,884	2
3												3
4												4
5												5
	Working Capital											
6	InterCo. Notes To/From CRC											6
7	Michealsen	XX		Working Capital	O/S Balance	02/01/94	(2,472,340)	(5,803,582)	n/a	variable		7
8	Colonial House	XX		Working Capital	O/S Balance	02/01/94	(1,208,060)	(1,161,571)	n/a	variable		8
9	TOTAL Facility Related						\$ 3,959,933	\$ (712,426)			\$ 428,878	9
	B. Non-Facility Related*											
10	Interest income offset										(376,741)	10
11												11
12	Amort. Of loss on EE of debt										16,134	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (360,607)	14
15	TOTALS (line 9+line14)						\$ 3,959,933	\$ (712,426)			\$ 68,271	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Covenant Health Care Center-Batavia**# **0025577**Report Period Beginning: **02/01/00**

Ending:

01/31/01**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																
1. Real Estate Tax accrual used on 2000 report.		\$ 15,106	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 15,549	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 443	3																													
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 7,397	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 7,840	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1996</td><td></td><td>8</td></tr> <tr><td>1997</td><td></td><td>9</td></tr> <tr><td>1998</td><td>12,299</td><td>10</td></tr> <tr><td>1999</td><td>14,416</td><td>11</td></tr> <tr><td>2000</td><td>15,549</td><td>12</td></tr> </table>	1996		8	1997		9	1998	12,299	10	1999	14,416	11	2000	15,549	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2000 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1996		8																														
1997		9																														
1998	12,299	10																														
1999	14,416	11																														
2000	15,549	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Batavia COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Barry C. Scuttillo, CPA

TELEPHONE (954) 721-5222 FAX #: (954) 722-6692

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>12-15-177-012</u>	<u>Covenant Health Care Center Inc.</u>	\$ <u>17,298.12</u>	\$ <u>17,298.12</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>17,298.12</u>	\$ <u>17,298.12</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES XX NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

A.

Square Feet:

36,884

B.

General Construction Type:

Exterior

Masonry - Brick

Frame

Number of Stories

C.

Does the Operating Entity?

XX

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

XX

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

XX

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

The Holmstad is a residential independent living facility for senior adults: 302,869 square feet and 318 units

Park Manor is a division of the residential independent living facility which has assisted services for senior adults: building F(44 out of 64 apartments in building F) and 44 units

Colonial House is License for 49 bedssheltered care facility: 29,647 square feet and 27 rooms.

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

XX

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1979 - 1980	\$ 86,624	1
2					2
3	TOTALS			\$ 86,624	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	128	1980	1980	\$ 2,454,000	\$ 76,388	33	\$ 74,364	\$ (2,024)	\$ 1,524,090
5	49	1977	1977	818,006	24,535	33	24,788	253	575,582
6									
7									
8									
9	Improvement Type**								
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Building Improvements - Michealsen	1982	\$ 8,904	\$ 145	30	\$ 297	\$ 152	\$ 5,292	37
38		1983	17,320	532	30	577	45	9,864	38
39		1984	1,040		10			1,040	39
40		1988	9,128		10			9,128	40
41		1989	18,984		10			18,984	41
42		1990	40,083	1,924	10	2,007	83	40,083	42
43		1991	18,354	1,835	10	1,836	1	17,442	43
44		1992	18,931	1,893	10	1,893		16,091	44
45		1993	90,076	4,504	10	9,008	4,504	67,560	45
46		1994	56,935	2,847	10	5,694	2,847	37,011	46
47		1995	84,370	4,219	10	8,438	4,219	46,409	47
48	Window Treatment	1996	9,675	484	10	967	483	4,352	48
49	Cubicle Curtain	1997	544	27	10	54	27	213	49
50	Door	1997	378	19	10	38	19	131	50
51	Cubicle Curtain	1997	3,495	175	10	350	175	1,094	51
52	Cubicle Curtain	1997	153	8	10	15	7	59	52
53	Locks for Lockers	1998	1,514	138	10	151	13	453	53
54	Awnings for patio	1998	1,428	64	10	143	79	355	54
55	Awnings for patio	1998	1,428	44	10	143	99	334	55
56	Café Wallpaper	1998	852	30	10	85	55	202	56
57	Permit for UST Installation	1998	528	12	10	53	41	119	57
58	Kitchen Renovation	1999	912	100	10	91	(9)	178	58
59	Kitchen Renovation - Counter	1999	1,269	70	10	127	57	198	59
60	Awnings	1999	938	32	10	94	62	128	60
61	Awnings	1999	938	26	10	94	68	120	61
62	Smoking area Receptacles	1999	467	12	10	47	35	59	62
63	Window Cornice	1999	569	14	10	57	43	72	63
64	Countertops and Sinks	2000	2,810	70	10	268	198	268	64
65	6 Wire Shelf Truck	2000	1,002	25	10	92	67	92	65
66	Ceiling fans	2000	1,870	47	10	117	70	117	66
67	Door Lock	2000	1,532	38	10	75	37	75	67
68	Roof Repair	2000	2,597	64	10	44	(20)	44	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,671,030	\$ 120,321		\$ 132,007	\$ 11,685	\$ 2,377,239	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 3,671,030	\$ 120,321		\$ 132,007	\$ 11,685	\$ 2,377,239	1
2	Land Improvements - Michealsen	1980 195,783	7,390	20	1,997	(5,393)	195,783	2
3		1982 780	39	20	39		692	3
4		1986 14,644		20	732	732	10,916	4
5		1987 12,022		20	601	601	8,526	5
6		1988 1,368	68	20	68		944	6
7		1989 520	32	20	26	(6)	338	7
8		1989 17,748	827	20	888	61	10,212	8
9		1990 4,592	155	20	230	75	2,415	9
10		1991 11,423	697	20	571	(126)	5,425	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,929,910	\$ 129,529		\$ 137,159	\$ 7,629	\$ 2,612,490	34

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

02/01/00

Ending:

01/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,929,910	\$ 129,529		\$ 137,159	\$ 7,629	\$ 2,612,490	1
2	Building Improvements - Colonial House	1982	4,198	148	30	140	(8)	2,729	2
3		1983	657	24	30	22	(2)	405	3
4		1984	208		10			208	4
5		1986	29,215		10			29,215	5
6		1987	21,856		10			21,856	6
7		1988	11,310		10			11,310	7
8		1990	4,698		10			4,698	8
9		1991	1,227	61	10	60	(1)	1,227	9
10		1992	2,991	299	10	299		2,841	10
11		1994	7,673	384	10	767	383	5,754	11
12		1995	150	7	10	15	8	97	12
13	Carpeting	1996	18,620	931	10	1,862	931	9,067	13
14	Drapes	1997	1,883	94	10	188	94	739	14
15	Carpeting	1997	210	11	10	21	10	83	15
16	Carpeting	1997	537	27	10	54	27	199	16
17	Carpeting	1997	2,511	126	10	251	125	925	17
18	Bathroom Tile	1997	139	7	10	14	7	51	18
19	Carpeting	1997	1,331	66	10	133	67	479	19
20	Carpeting	1997	245	12	10	24	12	85	20
21	Drapes	1998	203	10	10	20	10	54	21
22	Permit for UST Installation	1998	72	4	10	7	3	16	22
23	Drapes	1999	10,490	525	10	1,049	524	2,026	23
24	Carpeting	1999	256	13	10	26	13	48	24
25	Carpeting	1999	450	23	10	45	22	73	25
26	Floor Covering	1999	244	12	10	24	12	25	26
27	Toilet	1999	174	9	10	17	8	18	27
28	Floor Covering	2000	268	13	10	27	14	27	28
29	Border	2000	1,511	38	10	75	37	75	29
30	Crypton Fabric	2000	449	11	10	18	7	18	30
31	Wall Covering	2000	227	6	10	9	3	9	31
32	Window Treatment	2000	4,178	104	10	120	18	120	32
33	Roof Repair	2000	7,509	188	10	206	18	206	33
34	TOTAL (lines 1 thru 33)		\$ 4,065,600	\$ 132,682		\$ 142,652	\$ 9,971	\$ 2,707,173	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,065,600	\$ 132,682		\$ 142,652	\$ 9,969	\$ 2,707,173	1
2									2
3	Land Improvements - Colonial House	1990	3,528	177	20	177		2,030	3
4		1991	2,508	125	20	125		1,316	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,071,636	\$ 132,984		\$ 142,954	\$ 9,969	\$ 2,710,519	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number **Covenant Health Care Center-Batavia**# **0025577**

Report Period Beginning:

02/01/00

Ending:

01/31/01**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 442,893	\$ 40,836	\$ 41,425	\$ 589	10	\$ 248,977	71
72	Current Year Purchases	286,583	13,894	14,429	535	10	14,429	72
73	Fully Depreciated Assets	464,252				10	464,252	73
74								74
75	TOTALS	\$ 1,193,728	\$ 54,730	\$ 55,854	\$ 1,124		\$ 727,658	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,351,988	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,714	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,808	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,093	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,438,177	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES ☒ NO

10. Effective dates of current rental agreement:

Beginning

Ending _____

11. Rent to be paid in future years under the current rental agreement:

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 2,102 Description: Equipment Rental (Sch V, Line 35)

(Attach a schedule detailing the breakdown of movable equipment)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </div> <p style="font-size: small;">If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	hrs	\$	219	\$ 9,297	\$	219	\$ 9,297	1
2	Licensed Speech and Language Development Therapist	10A	hrs		41	1,701		41	1,701	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs		169	7,032		169	7,032	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts		12,948		321,975	12,948	321,975	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-ray	39			1,054	56,438		1,054	56,438	13
14	TOTAL			\$	14,431	\$ 74,468	\$ 321,975	14,431	\$ 396,443	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 176,265	\$ 17,226,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	359,922	9,864,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		11,414,000	5
6	Prepaid Insurance	5,470	1,157,000	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 541,657	\$ 39,661,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		93,058,000	12
13	Land	423,734	17,382,000	13
14	Buildings, at Historical Cost	3,939,453	319,433,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	698,855	41,970,000	16
17	Accumulated Depreciation (book methods)	(3,011,638)	(129,643,000)	17
18	Deferred Charges	162,466		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,086,046	39,505,000	21
22	Other Long-Term Assets (specify):		19,824,000	22
23	Other(specify): <u>Construction in Progress</u>	908,064	46,224,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,206,979	\$ 447,753,000	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,748,636	\$ 487,414,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,512	\$ 11,829,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		8,139,000	28
29	Short-Term Notes Payable		3,685,000	29
30	Accrued Salaries Payable	282,940	5,053,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,779		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,566		32
33	Accrued Interest Payable	58,744	1,621,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	10,927	5,427,000	36
37	<u>Current Maturities - Long term debts</u>	134,160	5,900,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 609,628	\$ 41,654,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,956,101		40
41	Bonds Payable		197,962,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany accts, other liabilities</u>	(6,938,304)	8,529,000	43
44	<u>Deferred Revenue</u>		171,338,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (982,203)	\$ 377,829,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (372,575)	\$ 419,483,000	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,121,211	\$ 67,931,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,748,636	\$ 487,414,000	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,696,853	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,696,853	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	413,660	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Designated Contributions	11,081	15
16	Other (describe) Planned Giving Assessment	(383)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 424,358	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,121,211	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning: 02/01/00

Ending:

01/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,536,975	1
2	Discounts and Allowances for all Levels	(1,069,707)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,467,268	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,768	6
7	Oxygen	17,723	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 383,491	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	56,981	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	10,830	15
16	Rental of Facility Space		16
17	Sale of Drugs	356,518	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	112,681	19
20	Radiology and X-Ray		20
21	Other Medical Services	198,712	21
22	Laundry	74,499	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 810,221	23
D. Non-Operating Revenue			
24	Contributions	10,584	24
25	Interest and Other Investment Income***	376,742	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 387,326	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment Rental	20,960	28
28a	See attached list	3,395	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,355	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,072,661	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,429,654	31
32	Health Care	3,275,121	32
33	General Administration	1,815,067	33
B. Capital Expense			
34	Ownership	626,534	34
C. Ancillary Expense			
35	Special Cost Centers	512,625	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,659,001	40
41	Income before Income Taxes (line 30 minus line 40)**	413,660	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 413,660	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Covenant Health Care Center-Batavia**# **0025577**Report Period Beginning: **02/01/00**Ending: **01/31/01****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,824	4,229	\$ 121,069	\$ 28.63	1
2	Assistant Director of Nursing	7,708	8,281	192,065	23.19	2
3	Registered Nurses	48,753	52,305	969,093	18.53	3
4	Licensed Practical Nurses	3,287	3,665	64,076	17.48	4
5	Nurse Aides & Orderlies	76,946	84,972	1,076,068	12.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,195	2,360	61,953	26.25	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,961	3,187	41,365	12.98	9
10	Activity Assistants	5,173	6,041	72,621	12.02	10
11	Social Service Workers	4,718	5,271	74,953	14.22	11
12	Dietician					12
13	Food Service Supervisor	5,331	5,827	95,772	16.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,642	30,063	280,189	9.32	15
16	Dishwashers					16
17	Maintenance Workers	3,334	3,587	70,223	19.58	17
18	Housekeepers	20,836	23,398	220,251	9.41	18
19	Laundry	3,912	4,353	48,486	11.14	19
20	Administrator	3,913	4,439	188,022	42.36	20
21	Assistant Administrator					21
22	Other Administrative	915	1,046	23,081	22.07	22
23	Office Manager	2,049	2,260	36,036	15.95	23
24	Clerical	16,772	18,595	250,951	13.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,692	2,054	29,366	14.30	31
32	Other Health Care(specify)	4,119	4,200	47,192	11.24	32
33	Other(specify) <u>Rounding</u>					33
34	TOTAL (lines 1 - 33)	246,080	270,133	\$ 3,962,832 *	\$ 14.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	150	\$ 4,485	Ln. 1, Col 3	35
36	Medical Director	Monthly	12,000	Ln. 9, Col 3	36
37	Medical Records Consultant	Monthly	3,696	Ln. 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,416	Ln. 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	150	\$ 21,597		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,497	\$ 193,902	Ln.10, Col 3	50
51	Licensed Practical Nurses	463	14,344	Ln.10, Col 3	51
52	Nurse Aides	3,651	72,423	Ln.10, Col 3	52
53	TOTAL (lines 50 - 52)	8,610	\$ 280,669		53

XIX. SUPPORT SCHEDULES

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life services Network \$4,694
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,294 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO XX If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 70,272
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,480
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte & Touche, CPA's The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.